

Next Meeting – Monday, April 7, 2008 – 2 PM
Appoquinimink State Service Center
Middletown, Delaware

STATE COUNCIL FOR PERSONS WITH DISABILITIES
BRAIN INJURY COMMITTEE
January 7, 2008 – 2:00 PM
Appoquinimink State Service Center
Middletown, DE

PRESENT: Brian Hartman, Co-Chair; Dr. Jane Crowley, A.I. DuPont Hospital; Laura Cygan, DPH; Devon Dorman, BIAD; Tony Horstman, SCPD; Lora Lewis, DPH; Mike Merrill, VR/U.S. DVA; Dr. Bradley Meier, DPC; Tom Parvis, DVR; Al Rose, DDC; Liz Schantz, Consumer; Mary Soligo, Christiana Counseling; Wendy Strauss, GACEC; Kyle Hodges, Staff and Linda Bates, Support Staff

ABSENT: Ray Brouillette, Easter Seals; Linda Heller, DSAAPD; Virginia Corrigan, Christiana Care; Aaron Deede, Consumer; Ellen deVrind, Christiana Counseling; Dr. Dan Keating, Bancroft Neurohealth; Janet Leitch, Consumer; Chris Long, DDDS; Beth Mineo Mollica, DATI; Ann Phillips, Parent and Dawn Stewart, Healthy Living

GUESTS

Gina Perez, Advances in Management
Betsy Wheeler, Wheeler & Associates Management Services, Inc.

CALL TO ORDER

The meeting was called to order at 2:10 PM.

APPROVAL OF MINUTES

Motion was made, seconded and approved to accept the October 1, 2007 meeting minutes as submitted.

AGENDA ADDITIONS/DELETIONS

- Life Conference
- DOE TBI School District Training

BUSINESS

Delaware Health Information Network (DHIN) Presentation

Due to no PowerPoint equipment being available, Gina Perez gave the following verbal overview of the DHIN.

Liz Schantz is a representative from the SCPD on the Consumer Advisory Committee. The Department of Veterans' Affairs has one of the finest integrated systems in terms of medical records in the Country and has been a model for what the DHIN represents. The big difference in Veterans' Affairs is that it is a population that they have control over. If you are a veteran or military personnel, you have a number and a record that is associated with the DHIN; whereas the State program is looking at all people in the state of Delaware so they really have no control.

Gina will be talking about what DHIN is, who is involved in it, how it works and what the benefits are to healthcare providers in the State as well as consumers of healthcare in the State of Delaware.

The DHIN is a system by which clinical information is exchanged. It is a network of real time information between healthcare providers, physicians, laboratories, hospitals, radiology facilities and nursing homes. The desired outcome is to improve patient health outcome for all residents of Delaware to improve the relationship between patients and providers in Delaware so there is more communication and information available to the people providing the healthcare and the people receiving healthcare. Also, the impact could help to maintain the rising healthcare costs.

How the DHIN works—in 1997 the General Assembly and Governor created a law that established the DHIN. The intent was to advance the creation of a statewide health information and electronic data interchange network for public and private use; to be a public-private partnership for the benefit of all citizens of Delaware; and to address Delaware's needs for timely, reliable and relevant health care information. Basically, what they thought then before the technology that is available today was that if people could have information faster and more reliably, they would make better healthcare decisions and patients would have more information in order to make better decisions about their healthcare. Aboard of directors was established and comprised of physicians, health providers, state organizations, consumers, insurance companies and business leaders. This board for the last ten years has tried to figure out how to make this all work. For the first few years, they focused on the claims processing. All the health care insurance companies started to do this on their own. Now, most claim processing is done electronically. The physician sends an electronic claim, the health plan provider reviews that electronically and remits their payment electronically so no paper is exchanged on the administrative side. Then they looked at their role regarding HIPPA by looking at how they could help hospitals and physician practices implement the HIPPA requirements. However, everyone was doing their own thing and there was no one role for them. The, nationally there came an interest in Health Information Exchange and technology of how they could support the clinical information exchange among health care providers. When a test result is ordered from a physician, the results get faxed back to them or sent via courier or mail which means it could be weeks before they get the test results. So, if they could do something to speed that process, it would make an impact. In 2004, Gina became the project director and it took until 2007 to go live once the vendor (Nudicity, Inc. from Salt Lake City) was identified which means that this is a

slow process due to the amount of work to be done. One of the planning groups formed was the Consumer Advisory Committee in 2004. The role of this committee is to develop patient privacy policies; advice on consumer education information and activities; and advise on patient portal development and functionality.

Why do we need the DHIN? Most doctors receive laboratory results from five different labs all sending results in a different format and method. Clinicians who use a computerized records system are more likely to adhere to clinical guidelines. Missing information is judged to adversely affect care in 44% of visits and delay care in 59% of visits. Using DHIN, the test results are immediately available to the physicians and will “red” flag urgent test results to be looked at immediately by the physician. DHIN presents medical records/test results in a standardized format to the physician. At this point, DHIN is delivering results only to the physicians and anyone else that is copied.

The next phase of the system is when someone goes to a specialist. If they need prior test results, they could query DHIN based on the relationship that you have established with them and ask for the results for the patient’s prior test provided that this information is in the system. If the patient decides to switch doctors, the patient will sign a DHIN release form, and the new doctor can go into DHIN for the results. DHIN runs audits to make sure that the patient release has been signed. Date of birth, addresses, phone numbers and record/case numbers are being checked, and patients can “opt out” of the DHIN system (which is being figured out at this point). When DHIN moves to the next phase—Patient Record Inquiries—the physician can actually go in and say that they want to establish a relationship with the patient and they want to see the patient’s records, that is when they need to have the ability for the patient to “opt out”. They should go live this summer. Mike gave an example that a log system is kept to identify anyone that accesses his records in the Veterans Administration system. Brian added that it would be harder to falsify records in this system. In the second phase, the patient can look at their own records to see who is authorized to look at their records. Also, a physician can forward results to another physician electronically if they are a DHIN user—or via fax if they are not in the DHIN system. One of DHIN’s goal is to look at regional and national health exchanges. The Delaware hospitals that are on line now are Christiana, Lab Corp, Beebe and Bayhealth. There are about 40 practice sites which includes 275 users.

Gina stated that they are working with the Mental Health system now. Both NAMI and the Mental Health Association are on their committee now. Gina will be meeting with the social security office in February. Only tests done from May of 2007 will be in the DHIN system. In the next phase in fall, prescriptions will be in the system. Right now, physicians can send info to the Veterans Administration, but the VA cannot send out information. Mike offered Gina the opportunity to come over and see how the VA system works.

Gina added that when the physician is able to query the DHIN system, they will be able to chart, for example, a person with diabetes. In the patient portal, long term, the patient would be able to go in and put information that would be sent to the physician and would be put into their medical information and record. This will happen maybe in 2010 or

2011. The physician has to watch for what results come to them and what action has to be taken.

The system itself cost \$26 million from state, private and federal funds—and \$1 million a year to operate. The budget is \$8 million a year which is not all spent. The Delaware Health Care Commission is the administrative arm of the DHIN system which contracts with Gina.

Gina will send a list of people using the system to Kyle. Also a copy of the power point will be sent to Kyle to distribute to the committee members.

Year 3 of TBI Implementation Grant & Ideas on Spending Year 2 Money

Lora completed the draft of the TBI grant for year three. A reduction in funds is expected for year three. Lora is submitting a budget based on the same amount of money as last year's budget, but DE could get \$100,000 or less. The contractors will be getting less money this year than last year. An Administrative position has to be added to the grant which will affect the budget as well. Basically, everything is pretty much planned as year two—the Ambassador Program, BIAD outreach, working with BIC developing educational activities, and Betsy will wrap up facilitation of the workgroups. There is a little bit of money for evaluation. In year two, self-evaluation tools are being created since there will be no money in year three.

Brian asked when we will know what the definite budget amount. Lora replied that we will not know until they award it around April 1. So, Lora is basing her contract on a lower amount since the amount awarded is not known. The contract can be amended also. Lora is talking with the contractors and letting them know that there will be a 20% reduction across the board. Lora will send Kyle the final version. Kyle noted that \$5,500 was spent on the BIA conference; and there is \$3,500 left to be spent on the “education plan” (e.g. materials) and training by the end of March. Two professional development trainings will be provided this month via Jane, Kyle and Wendy. Part of the money will be paid to Jane for doing the trainings. Kyle asked for additional ways to help spend the \$3,500 by the end of March. Lora suggested the Bicycle Rodeo Riding through Ginny Corrigan which would provide helmets and they cost \$5.50 a piece. Brian suggested giving to the police and asking them to give out \$5 gift cards to McDonalds, Best Buy, etc. to kids who are wearing their helmets. Lora said that this could be part of the rodeo with permission from the police. Kyle would need to speak with Ginny Corrigan for information on the rodeo and the bicycle helmets. Also, if the BIAD needs \$ for the website, that could be a good way BIC could spend the money. Devon will send the cost of the site program to Kyle. Tom added that the YMCA has a lot of outreach for children (e.g. helmets)—that is statewide and reaches the public directly. Given the timeline, there may not be enough time this year; however, this would be a good idea for next year. Laura added that Emergency Medical Services for Children could be a good outlet for bicycle helmets. Laura will interface with Marie and get the cost. Devon added that March is Brain Injury Awareness month and they would be advertising on DART, etc. Devon will send a write up to Kyle of what is needed.

Mary added that in her practice, the brain shaped tablets are a hit. Devon added that there are brain-shaped erasers, lollipops, etc.

Jane distributed brochures on concussions that the Ambassadors Program is distributing to the emergency rooms, the trauma divisions, and the high schools. Jane added that hopefully the brochures can be placed in the primary care physicians in the future. They are aimed at parents for outreach. A Spanish version could be an option for funding. The BIAD has a Spanish version—which Devon distributed to the Committee.

Kyle suggested that the first priority of the \$3,500 be the BIAD; then the helmets funding and the Ambassador Program. All agreed.

ABI Waiver Update—DSAAPD

Lisa Bond gave the following update. The CMS approved the ABI waiver in November with an effective date of December 1. Service providers have been found for each of the eight services to cover each of the counties. In the area of Day Rehabilitation and Cognitive Services enough providers have been found to get started. There are 50 slots available in the first year, so there will be coverage but no client choice, which DSAAPD would like to be able to give. The goal is to have two service providers in each county. For Day Rehabilitation in New Castle County, DSAAPD is working with Point of Hope. For Kent and Sussex Counties, they just contracted with Kent Sussex Industries. For Cognitive Services, there are two providers for New Castle County and one for Kent/Sussex Counties. Lisa will provide a list of providers for both services to Kyle.

Persons are offered the opportunity to roll over from other waivers. A roll over of persons will happen in January and February. DSAAPD will start with people in assisted living facilities. Brian asked if the budget is \$700,000 this year and \$1.4 next year. Lisa will get the exact numbers to Brian before the March Joint Finance Committee meetings. December 1, 2008 is the start of the waiver year, and then 10 more could be added.

Lisa noted that the age range is 18 years and older and the date of injury can occur before that age. Lisa went to Peachtree and DSAAPD will provide a presentation whenever asked. More waiver information will be on DSAAPDs website and also there will be a presentation at the Life Conference. A one page flyer with this information was suggested to Lisa.

PATBI Report

I. DHSS BUDGET TESTIMONY

Brian presented testimony on behalf of the DLP, SCPD and DDC at the November 28, 2007 DHSS budget hearing. Copies of the presentation, minus attachments, were included with this report. Brian also included Secretary Meconi's presentation on the entire DHSS budget which includes his observation that CMS has approved the ABI waiver expected to be implemented commencing December 3, 2007.

A. DSAAPD Budget

The presentation on the DSAAPD budget focused on the new ABI waiver. For FY 09, enhanced funding will be needed to cover full-year funding and increase the participant cap from 50 to 60 individuals. To achieve that result, the State match would have to increase from the \$700,000 in the FY 08 budget to \$1.2 million in the FY 09 budget.

B. DDDS Budget

The presentation on the DDDS budget focused on the latest attempt to initiate a “family support waiver”, now renamed a “self-directed support waiver”. The “content” and services menu of the new waiver proposal is almost identical to the one proposed for FY 08. Three month funding is sought. However, DDDS proposes to divert funds from residential services to the waiver rather than seeking a discrete allocation of funds for the new waiver.

C. DSAMH Budget

The presentation on the DSAMH budget focused on the need for community-based residential options (e.g. supervised apartments and group homes). DSAMH lacks sufficient capacity in community-based residential options. Parenthetically, DSAMH announced in November that it planned to transition 35 patients from DPC to the community by February 1. A November 27 News Journal article was provided. Brian shared his concern that such discharges be to appropriate supportive settings as juxtaposed to shelters and motels.

II. CMS ABOLISHMENT OF REGIONAL OFFICES

Consistent with a December 28 email, CMS has abolished its 10 regional offices. Four “consortia” are established to ostensibly cover at least some of the work formerly done by field offices. This change could affect the processing of waiver applications.

Brian added that after he made this report, information came out that they are not abolishing its regional offices.

III. GOVERNOR’S TASK FORCE REPORT ON DPC

On December 18, the Governor’s Task Force on DPC issued its final (56 page) report. It can be downloaded from the Governor’s website. The Executive Summary is attached (pp. 14-18) which lists the Task Force’s top recommendations. The Task Force recommends: 1) creation of an oversight committee to monitor DPC; 2) contracting with an experienced state hospital or organizational expert to spend 6 months at DPC; 3) hiring an experienced performance improvement director; 4) hiring a hospital director with clinical experience in a behavioral health field; 5) reclassification of “unit directors” to “nurse managers”; 6) leadership training in minimizing use of seclusion and restraint;

7) notification of DLP of all allegations of abuse/neglect; 8) “rapid expansion” of community services; 9) allotment in annual budget to transition patients to community; and 10) construction of new DPC facility after further study.

Brian was advised that the DSAMH Director announced at the December DSAMH Advisory Council meeting that the DLP will be given associate status on the Council and be provided with abuse/neglect information automatically. Consistent with the attached January 4 News Journal article, the Governor indicates that DHSS plans to implement many of the report recommendations during the next 3 to 9 months. These are favorable developments.

Brian added that if there are more living options (i.e. group homes) in the community, you do not need to have fewer hospital beds. A group home has not been funded since 2002.

IV. DDDS ELIGIBILITY REGULATIONS

The SCPD adopted Brian’s commentary on the latest version of the proposed DDDS eligibility regulations in October, 2007. DDDS was still reviewing and considering comments in December. The earliest date for publication of final regulations would be February 1, 2008. The delay could be viewed as “good news” since advocates would prefer a significant revision to adoption of the October version of the standards.

V. NEW DLP “VICTIMS OF CRIME” PROJECT

A. BACKGROUND: The Disabilities Law Program (DLP) is a provider of free, civil legal assistance to persons with disabilities based on several federal grants. The Criminal Justice Council recently awarded the DLP a new grant focusing on advocacy on behalf of persons with disabilities who are victims of crime.

B. EFFECTIVE DATE: The project period is October 1, 2007 through September 30, 2008.

Brian added that the final approval was not received until November of 2007.

C. CLIENT ELIGIBILITY: There are no financial (income; resource) caps. There are no age limits, i.e., both children and adults may be served. Project is statewide. Clients may reside in institutions or in the community. The following Americans with Disabilities Act (ADA) definition of “disability” is used:

The term “disability” means, with respect to an individual -

- (A) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (B) A record of having such an impairment; or
- (C) Being regarded as having such an impairment.

D. SCOPE OF SERVICES: DLP staff will provide legal guidance and direct representation to eligible clients to secure access to resources and available civil legal remedies necessary to stabilize their lives after victimization. Legislative, regulatory and systemic advocacy is not an authorized activity.

E. ANTICIPATED CONTEXTS OF ADVOCACY:

1. Institutional Abuse & Neglect [(e.g. DPC Victimization]
2. Financial Exploitation [e.g. Consumer Fraud; Misappropriation of Funds]
3. Domestic Violence [Protection from Abuse (PFA) Proceedings]
4. Violent Crimes Compensation Board Claims
5. Access to Medical Care Related to Victimization [Medicaid; Insurance]

F. COLLABORATION & REFERRALS: The DLP anticipates collaboration with several agencies to facilitate referrals, including the Long-term Care Ombudsman, Adult Protective Services, Division of Long-term Care Residents Protection, and DAG's Medicaid Fraud Unit.

G. SOURCES OF INFORMATION [BEING UPDATED]

1. Website--www.declasi.org
2. Pamphlets

Brian added that their website and pamphlets are being updated to include this new program.

Brian will send a one pager to Kyle to distribute to all on this project.

Vacant Chair Position

Kyle announced that John Goodier has resigned as the BIAD President and the BIC Chair and from the SCPD committee. Devon Dorman became President at BIAD as of January 1, so it was agreed she will be co-chairing BIC.

ANNOUNCEMENTS

Brochures were distributed for the Life Conference on January 24 at the Dover Sheraton. If you need information or would like to be registered, please contact Kyle or Linda.

A hand-out was provided on a Disability Awareness Legislative Day to be held on March 19. The issues that will be talked about are the SCPD priorities. This event involves getting people with disabilities to get appointments with their legislators to talk about these issues. The issues to be promoted are: MFP; Medicaid Buy-In; Funding for Community Based Services; Community Based Ombudsman and Bill of Rights; ABI

Waiver; Self-Directed Services Program and Speech Language Pathologists funding. There will be a training in the morning to give guidance on addressing these issues with their legislators. Please register with Linda.

Brian would like to get Public Health's endorsement for the Bike Helmet bill supporting the mandatory wearing of helmets for 16-17 year olds. Information will be given to Lora to obtain a letter of endorsement from Public Health. Al added that maybe a letter of endorsement from Secretary Mitchell would be helpful—all agreed. Kyle will contact Secretary Mitchell for a DSHS endorsement also.

ADJOURNMENT

The meeting was adjourned at 3:45 pm.

Respectively submitted,

Kyle Hodges
SCPD Administrator

S:bic/08janmin